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ORIGINAL ARTICLES

CANCER OF THE STOMACH WITH REPORT OF END RESULTS IN SIXTY-FIVE CASES.*

By P. E. Truesdale.
Fall River, Mass.

Cancer of the stomach is generally recognized as one of the most despairing forms of neoplasm occurring in the human body. Unlike cancer elsewhere, such as in the breast, uterus, and rectum, it cannot be seen, nor can it always be felt upon examination. During the period when there is a chance for cure by extirpation, it is concealed and very often inoffensive. While cancer is far more common in the stomach than in the breast, we have removed cancer of the breast nearly twice as often. This means that, as a rule, patients will accept operation early if the facts are made clear to them.

The medical profession has been blamed for not discovering gastric cancer in its incipiency. This is unjustifiable because it cannot be done at present in a large group of cases. We are approaching better results with more accurate means of diagnosis, and by giving the general public all facts they should know about cancer. But we have not arrived at a higher point of perfection in diagnosis than is shown in the production of one case of cancer of the stomach out of six examined which has any chance whatsoever for cure by surgical measures, and the mortality from any other form of treatment is 100%.

The difficulty in recognizing cancer of the stomach early has been expressed clearly by Graham, who said, "At present it must be admitted that the problem of diagnosis is quite insurmountable. The disease may be so insidious in onset, so lacking in urgent early symptoms that the patient is beyond help before pain or other danger signals have awakened him to his condition. He may present himself with such trifling trouble apparent that even a careful clinician is not aroused to the gravity of the situation, and the patient is lightly dismissed only to await the fatal period. He has appeared at the clinic not from any grave fear, but rather because of loss of appetite for a few weeks, loss of flesh, strength and color, because he is unable to exert himself, or because some friend has urged him to undergo examination."

Billroth was the first surgeon to operate for cancer of the stomach. He did the first successful operation in 1881. His immediate mortality was 64%. In describing his operations, Billroth said, "The patients left the operating table in shock, from which some of them recovered." Naturally he was subjected to much criticism, but the mortality of medical treatment was, and is now, 100%. He cured a few, not many. Perhaps these were cancer, perhaps not.

Billroth said that his life was saddened by the number of patients with advanced malignancy who seemed to be attracted to his clinic. He was the only man of his period who gave them a chance based upon the principles which we are advocating today, two generations after his time.

The operative mortality at the Mayo clinic is about 7%, with about 22% living after five years. The general operative mortality in the larger hospitals is much higher, and the number of five-year cases is exceedingly small. These great differences may be explained in two ways. First. Any series of cases of gastric cancer operated upon by a large number of surgeons will invariably yield a high mortality rate. Second. The dividing line histologically between cancer and ulcer varies according to the concepts of the observer.

If the principles said to govern the origin, development, and treatment of cancer elsewhere in the body apply to cancer of the stomach, then I believe that surgeons who adopt radical measures in what appear to be borderline cases, will be rewarded by many five-year cures and some permanent cures. Radical excision of precancerous lesions, or potentially cancerous tissue, yields happy results while wide excision of a tumor, which to a bystander is obviously cancer, very rarely cures the disease.

*Read before the Providence Medical Association April 3d, 1922.

Making due allowance for the personal slant of the examiner as to operability of patients with cancer of the stomach, somewhat less than one-third are found to be reasonably hopeful risks for any operation planned to be helpful. In a series of 200 cases examined, we found 65 who presented enough on the bright side of the picture to warrant operation. Of this number, 30 were found to be inoperable when the abdomen was opened. Inoperability in this group was determined by extensiveness of the stomach involvement, and by the glandular, peritoneal, or visceral metastasis. Two died as a result of the interference.

Of the remaining 35, 18 were obviously incurable when the disease was exposed to view, but a palliative gastroenterostomy was done to offset existing obstruction. There were four deaths, 4½%.

The average length of life after this operation was eight months. The best one can report for these cases is that they improved for a few weeks or months, then remained unchanged for an equal length of time, and died from extension of the disease, not from starvation.

Partial gastrectomy was done in 17 cases. There was only one death from this type of radical operation. Mortality 6%. These were the most favorable cases for operation.

The majority showed a palpable tumor on examination. In many instances it could not be determined at the time of operation whether the tumor mass was benign or malignant. Only two are alive and apparently well, one eleven years after operation, and the other only nine months after operation. One lived seven years after operation, two lived more than three years, one lived two and one-half years, six lived between one year and a year and a half.

Two more cases should have been included in this series. In each the clinical diagnosis was ulcer, the operative diagnosis was ulcer, and the pathological diagnosis was ulcer. Yet both patients died of cancer in the upper abdomen. One lived more than three years and the other lived seven years. The remaining four could not be traced. So that it seems fair to report that of nineteen cases after radical operation the operative mortality was 5½%. Three lived more than five years, and six lived more than three years.

The radical operation is ambitious surgery. The choice of case for the operation governs the risk. The mortality can be made high easily, but if the end results are no better on the average than in this series of nineteen cases, I see no wisdom in operating on the more advanced cases.

The medical profession in general has not warmed up to the surgical treatment of cancer of the stomach, because, first, about 50% of the cases are found inoperable when the abdomen is opened.

Second. Operations upon the remaining 50% can be palliative in about half of this number.

Third. In the remaining 25% or thereabouts only is there a good chance to prolong life, and a fair chance of a five-year cure at least in a variable number, depending upon the type of tumor, the individual's defensive cells to cancer, and the character of the operation.

Although we are loath to do it, we must admit that this is a poor showing.

In the first group, as we find these patients, the operative mortality would be forbidding. The patients are usually poor surgical risks. Nothing worth while can be achieved by any known method of attack. Nevertheless, the true state of affairs could be determined only by laparotomy.

The second group calls for judgment in determining the case suitable for gastroenterostomy alone instead of partial gastrectomy.

The third group includes those obviously operable and demanding a higher grade of technical knowledge in order to expedite the operation without undue loss of blood.

All three groups fix upon us the importance of a single purpose, namely, to acquire a knowledge, a faculty, or some means to diagnose cancer of the stomach at its very beginning. A history of persistent indigestion with anemia and progressive loss of weight, in the absence of other lesions to explain the picture, in a patient over forty years old should excite suspicion, call for careful X-ray examination, and laparotomy if the symptoms cannot be explained otherwise.

William J. Mayo's comment, made in 1904, holds good today in spite of advances made since then in diagnostic methods. He said, "In an early exploratory incision we have the one diagnostic resource which is reliable and which must be resorted to in a large number of cases." A palpable tumor does not indicate an inoperable condition.

A movable tumor, especially if accompanied by obstruction, offers a favorable outlook.

Cancer at the cardia, at the fundus, and high on the lesser curvature, seldom gives rise to symptoms early enough to make it possible to relieve the patient by operation or any other known means.

On the other hand, the pylorus is the palpable portion of the stomach. Seventy-five per cent of gastric cancer occurs in this region. When the growth in its early stage is surrounded by a sufficient amount of inflammatory tissue to produce pain or impinge upon the lumen of the pylorus, there is a chance for surgery to accomplish as much here as in dealing with cancer of the breast or cancer of the colon.

To determine the presence of gastric cancer earlier we must make surgical examinations more often or rely upon the roentgenologist. In the X-ray department probably will be found the opportunity and the means to define the non-obstructing neoplasms at a period during their development, when there is a reasonable chance for cure by operation. Radium has no place in the treatment of cancer of the stomach, and the use of the X-ray for treatment is of very doubtful value.

What should constitute inoperability without actual surgical examination?

First. The anemic cachectic patient, with a palpable tumor to the left of the midline, obviously presents a hopeless picture.

Second. Secondary nodes above the clavicle, in the liver or in the pelvis contraindicate intervention.

Third. Free fluid in the peritoneal cavity is a sure sign of inoperability, since it indicates involvement of the liver or peritoneum.

Fourth. Induration at the umbilicus is indication of peritoneal involvement even in the absence of free fluid.

Finally, it must be clear to any thinking mind that the old way of approaching the stomach cancer problem will not get us anywhere. Where patients are treated in two camps, medical and surgical, the batting averages in end results are always low. The scent for cancer is not as keen when there is complete interdependence of the two main branches of practice. The very early cases of gastric cancer complain only of indigestion and loss of weight. An internist *and* a surgeon should co-operate in the study of such cases. The patient should not be assigned medical or surgical until a careful preliminary study has been made. The machinery for transferring a patient is often clumsy and the patient gets lost between the lines. During the war the French used a large admitting tent which they call the Triage. Here the wounded were seen by several doctors with a view to sorting out the cases. I believe that in every clinic there should be a sorting station for borderline cases, so considered by the admitting physician. Interchange of opinion at this point between internist and surgeon gives each a chance to register an opinion or suggestion. Examinations may proceed and conferences be renewed always to the edification of the attendants and invariably helpful to the patient.

Thus far it is obvious that some method of examination, less radical than laparotomy, and as effective, must be evolved before *end result figures* improve much.

Failure to cure cancer of the stomach is due to late warnings, late recognition, and late operation, not to surgery.

DIAGNOSIS OF DISEASES OF THE SCALP.*

By Roy Blosser, M.D.
Providence, R. I.

Although diseases of the hair and scalp are relatively common, the medical profession as a whole has given little attention to this subject. As a consequence, patients who suffer from these diseases usually drift around from one to another of the self-constituted hair specialists, beauty parlors, barber shops, and what not. It is now believed that many of the diseases of the hair and scalp are infectious. Owing to the fact that these so-called specialists have usually little idea of the importance of observing a proper technique in the handling of such cases, it is natural to conclude that they are often responsible for the spread of contagion.

Among the diseases of the scalp which most frequently lead the patient to seek medical or other aid are those causing loss of hair. This class of cases may be divided into those in which the hair

*Read before the Providence Medical Society April 3, 1922.

loss is circumscribed to one or more areas, and those in which it affects the entire scalp.

Circumscribed Loss of Hair. The most common disease causing circumscribed loss of hair is alopecia areata. This condition comes on rapidly, with complete loss of hair in areas ranging in size from a quarter of a dollar to a dollar or larger. The scalp is perfectly smooth and the surrounding hair appears normal except that on close examination a few short stumps of hair may be detected around the margin of the patch which, from their peculiar shape, are called "point of exclamation hairs." In rare cases the hair is entirely lost; such cases are called alopecia totalis.

Another disease causing loss of hair in circumscribed areas but differing in other respects from alopecia areata is ringworm of the scalp. This disease occurs in children between the ages of five and fifteen. It is extremely rare in adults. The loss of hair is irregular, and lacks the clean cut appearance seen in alopecia areata, and the denuded areas are covered with grayish scales. On close examination many broken off and twisted hairs are seen in the partially bald areas. Another, and less common variety of the disease, known as "black dot" ringworm, bears some general resemblance to alopecia areata. In this form of ringworm the hairs are broken off so close to the scalp that they resemble black dots.

In all cases of ringworm of the scalp the diagnosis can be confirmed by extracting some of the broken hairs and examining them under the microscope.

A suppurative condition known as kerion occurs as a complication of ringworm and consists of boggy swellings of variable size from which ooze sero-pus. There is no pocketing of the pus and hence nothing is to be gained by incising them.

A disease prevalent in some European countries but rarely seen in America except in immigrants is favus. The most common location of the diseases is the scalp, but it may also occur on other parts of the body. The typical lesion of favus is a small yellow crust with a central cup or depression. The fungus which causes the disease can be demonstrated microscopically.

Lupus erythematosus sometimes involves the scalp, being secondary to lesions on the face or other parts of the body. Occasionally it occurs on the scalp alone and in this location the characteristic features of the disease as seen on the face are lacking. There are one or more variously sized bald areas which are at first pink in color and slightly scaly, but later become pale and atrophic with a peculiar cribriform appearance due to the patent orifices of the hair follicles. Itching is usually a pronounced symptom.

Folliculitis decalvans is a form of alopecia in which the hair follicles are destroyed in numerous small atrophic patches which partially coalesce to form large irregular areas of baldness. It is a slowly progressive disease and causes permanent destruction of the hair follicles.

Other causes which produce circumscribed loss of hair are wounds and burns of the scalp, and syphilitic lesions of an ulcerative type which sometimes occur in the tertiary stage of the disease.

Generalized Loss of Hair

Among the diseases which result in a generalized loss of hair, premature hereditary alopecia is of rather frequent occurrence in males. The hair begins to fall out soon after the age of twenty. This may take place rapidly or it may be more gradual and occupy several years. In some cases the scalp appears to be perfectly healthy. In others, the condition may be aggravated and the loss of hair made more rapid by some form of disease of the scalp.

The hair loss accompanying various systemic diseases is known as alopecia symptomatica. There may be only thinning of the hair, or there may be complete baldness, but it is usually only a temporary condition and the hair grows in again when health is restored. This form of alopecia is a common occurrence following the exanthemata, especially measles and scarlet fever; many cases have occurred as a result of the influenza epidemics in recent years.

The alopecia of syphilis is well known. It is usually noted as a thinning of the hair occurring in the early part of the secondary stage. It also occurs in the form of ill-defined patches which give the scalp a "moth-eaten" or "mangy" appearance, but such cases are exceptional and usually occur later in the course of the disease.

The most frequent disease of the scalp causing general hair loss is some form of seborrhoeic alopecia. The term seborrhoeic was applied because

formerly it was thought that these diseases were due to an excessive flow of oil from the sebaceous glands. But it is now generally believed that they are microbic in origin and while they do occur as a rule in persons with greasy skins the greasiness merely acts as a predisposing factor by rendering the soil more fertile for the growth of bacteria.

A mild type of the disease is known as pityriasis capitis. There is more or less scaliness or dandruff, the hair is usually dry and lusterless and the scalp is itchy. The itching is relieved temporarily by shampooing but soon recurs. In some cases there is no loss of hair; in others it is noted that the hair comes out too freely from brushing. Baldness does not usually begin until the age of thirty-five or forty and is first noted at the vertex of the head or at the sides of the forehead.

A more serious form of the disease accompanied by an intractable type of baldness is known as pityriasis oleosa. There is pronounced oiliness of the scalp. In some cases the oil becomes waxy so that the scales adhere to the scalp. As Sabouraud remarks, "they fall no more but then it is the hairs which fall." It occurs most frequently in males but females are not exempt. In the latter it causes marked thinning of the hair but rarely absolute baldness. The disease usually begins soon after puberty but it occasionally occurs in young children in whom it persists throughout life.

The term seborrhoeic dermatitis has in the past been more or less loosely applied to the various seborrhoeic diseases of the scalp. Following Sabouraud's classification it is now usually limited to those cases in which there are definitely inflamed and reddened patches, covered with waxy scales or crusts, such areas not infrequently extending beyond the hair margin.

Diseases Unaccompanied by Loss of Hair

Among the diseases not attended with hair loss, pediculosis capitis and the secondary infections which follow it are extremely common in children. They make up a large percentage of the skin cases seen in the out-patient departments of our hospitals. But pediculosis is by no means limited to poor children. It occurs not infrequently among children of the well-to-do. In advanced cases the scalp becomes inflamed and excoriated and may be crusted from a secondary impetigo. The latter infection may be transferred to the face or other parts of the body. In such cases, if an examination of the scalp is neglected, the real cause of the trouble, pediculosis capitis, is not found.

Psoriasis of the scalp is easily diagnosed by the characteristic lesions occurring elsewhere on the body.

Among the skin lesions now known as neurodermatitis, first described by the French dermatologist Brocq, a fairly common and characteristic location is the lower part of the scalp near the nape of the neck. In this location the lesions differ somewhat from those seen elsewhere on the body, being scaly, red or pink in color and fairly sharply defined. This condition is accompanied by severe pruritus.

The disease known as sycosis barbae, a staplylococcic perifolliculitis, usually occurring on the bearded region in men, may also involve the scalp.

REMARKS OF ACCEPTANCE TO THE PRESIDENCY OF THE RHODE ISLAND MEDICAL SOCIETY

By
Dr. Frank E. Peckham.

Members of the Rhode Island Medical Society:

When a body of men like this society offers the highest office at its disposal, it makes one feel very humble indeed. I appreciate deeply the honor conferred and feel strongly the duties which it also imposes.

To me the profession of medicine is a big challenge, composed of very many smaller or subchallenges. The men making up this grand profession are men of varying ability. As each man develops his peculiar bent, he naturally fits in somewhere, because there are so many avenues in which he can accept the challenge which most appeals to his personal characteristics.

It has been said that men are individually less than 50% efficient in their effort and when a number of men are banded together in any effort the percentage of efficiency of the body politic is probably less than any individual.

During the coming year, with only a few meetings at my disposal, I shall try to have papers illustrating if possible some of these challenges so that we may become more cognizant of some of our deficiencies and in this way apply a stimulus to our energies both individually and collectively.

I sincerely thank you for the honor conferred upon me.

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The R. I. Medico-Legal Society—4th Thursday—January, April, July and October. Dr. Roswell S. Wilcox, President; Dr. H. S. Flynn, Secretary-Treasurer.

EDITORIALS

THE JANE FRANCES BROWN BUILDING.

With the recent opening of the Jane Frances Brown Building, the Rhode Island Hospital has been placed among the first in the eastern States, and, indeed, in the country, in the way of modern hospital facilities.

This building and its appointments is a commentary to the painstaking care and investigation attendant to its completion, and demonstrates that the actual structural work was not the greatest effort that the authorities having to do with its erection and equipment put forth, but better represents the end results of a great deal of preliminary investigations and forethought.

It might be thought, at first glance, that the schedule of fees, which may be found upon another page of the JOURNAL, is somewhat in excess of general expectancy. It has developed, however, that there are many who are not only able but entirely willing to pay for the skilled and exacting care and treatment made imperative by institutional training, especially when

coupled with elegant, not to say luxurious, accommodations and environment.

It will be noted also that the obstetrical ward, an entirely new departure of the Hospital, lends added attractiveness to the general hospital facilities.

ON MEDICAL EXPERT TESTIMONY.

At the last meeting of the American Medical Association the Chairman of the Section on Nervous and Mental Diseases expressed himself in no uncertain terms concerning the present status of medical expert testimony. He said that the usual practice of each side selecting experts who appear in court with a partisan label has led to many ills, not the least of which is the resulting public distrust of our opinions. And he went on to remark further that while psychiatrists share this burden with all medical and professional men such as chemists and engineers, they suffer relatively more damage to their reputations because cases involving questions of mental responsibility are prone to attract a great deal of popular interest and to be exploited by the sensational press. Under these circumstances, even the most friendly and discriminating lay people are tempted to question not the exactness of the physician's knowledge only, but also his common sense and perhaps at times even his sincerity. If medical men do not always appear sensible and trustworthy when under oath, how can they expect the public to trust them as advisers in their serious and intimate personal problems?

These are hard sayings and coming as they do from such a source, they merit our serious consideration. No one who is not hugging illusions can deny that, taking it on the whole, medical expert testimony is in ill repute. But to lay the whole blame for this state of affairs upon the physicians, as is frequently done, is to further neither justice nor the truth. Physicians, like other men, have to take things as they find them, and things as they find them at present with respect of expert testimony are not to the physicians' liking. Men who have the honor and the good repute of their profession at heart are concerned solely with helping courts and juries to arrive at the truth, to the end that justice may obtain between contending parties; but under the existing system such a result is, we do not say impossible, but certainly hard to attain.

To begin by calling us "physicians for the plaintiff" or "physicians for the defendant" is wrong in principle, and therefore bad in practice. It introduces an atmosphere of contentiousness, a spirit of partisanship, into an inquiry which ought to be a disinterested search for facts and an attempt at their right adjudication. There should be no display of rhetoric and no indulgence in verbal sophistries which cloud the mind and darken the counsel of judge and jury. But as things are now, the medical expert is placed in a false and to him most disagreeable position; for he seems to be, and indeed as examinations and cross-examinations are conducted, he is the advocate of *ex parte* opinions. Instead of being free to state his convictions, his doubts, his hesitations and ignorances as they issue from the alembic of his own mind, he is constrained to express himself in the way prescribed for him by legal formalism and the dialectics of the law schools. A partisan witness, in appearance if not in reality, he speaks with diminished authority to his fellows. For others outside his own ranks to tell him that he fails many times to convince is to supply him with quite superfluous information.

What, then, are we to do about it? Well, for one thing, we can publicly express our dislike of the present situation; more than that, it is difficult to say what we can do. So many factors enter into the problem that it is beset with thorns on every side, but this much is certain, that one of our problems for the future is—if we are to save and augment our self-respect—to make medical knowledge available for courts and juries in such fashion that physicians shall be not even in appearance, partisans of this side or of that, but protagonists of what they believe to be nearest to the truth.

HOSPITAL CLINICS.

The education of a physician does not end when he graduates from Medical School. In fact, it has only just begun. Nothing is sadder than to come into contact with men who have been in practice many years and who are still thinking in the terms of methods learned during their medical school course. Not only have they not pro-

gressed, but actually have forgotten much of what they were taught. Many physicians make some effort to inform themselves of what is going on in the medical world. They read medical magazines but because of lack of funds or inability to leave their practices, cannot attend conventions and clinics in medical centres. The income of the average physician is not large and when he lives in towns or cities remote from medical centres it is obvious that the privileges of continuing medical education are beyond his reach. Someday perhaps, educational facilities will be taken to him by the establishment of community hospitals to which will be sent competent clinicians who are able to teach; for medical teaching need not be confined to a few centres.

In Rhode Island, physicians are more fortunate than they are in other parts of the country, for we are near Boston and New York. Yet the opportunities of the clinics in these cities are not made use of as they should be. This applies not only to those who have no hospital connections, but to those who do have.

A logical and feasible scheme is to establish a definite set of clinics covering medicine, surgery and the specialties, to be held in the several hospitals of the State. The State is small and a doctor could attend forenoon clinic and return to his home in time for afternoon office hours. The expense would be trifling, and the doctor would not have to neglect his practice.

It would be stimulus to the hospital and the visiting staff to do better work if they are obliged to present before groups of physicians, patients for diagnosis and treatment. It would help the general practitioner to better evalulate new procedures and methods, clinical, laboratory, and surgical. Many new procedures must be discarded for every one which is found of real service.

There are several hospitals in the State which have a great deal of material and good facilities for teaching, and physicians and surgeons on their staffs who are capable of teaching if courses were arranged.

The object of this article is to urge the State Medical Society to choose a committee which should be given authority to approach the management of the hospitals which are, in their opinion, able to attract physicians to clinics, and arrange a series of clinics at each hospital. Each hospital staff could decide who would hold the clinics for doubtless some might not care to do it. The program for a year's work should be arranged and printed in as much detail as possible, certainly the time and the place of the clinics and the names of the physicians who are to conduct them. The exact diseases or operations to be presented might have to be announced to physicians of the State just preceding the clinics, for hospitals would not know long before hand what material would be available at the date of the clinic.

It is well to warn that not every clinic will have a large attendance. Much will depend upon the subject to be presented and the man who is to present it. But if only one physician attends, the clinic would justify itself. In fact, inoperative clinics and medical clinics held at the bedside, should always be small, for each physician attending would feel free to ask questions and discuss the subject in hand. It must be realized that the man who holds the clinic receives quite as much good from it as the physician attending. In this manner the hospitals of the State would be urged to better work and serve as educational centres which they will generally someday. Physicians generally would be benefited and do better medical work and the public thereby receive the benefit of improved service.

SPRING VACATIONS FOR PHYSICIANS.

Most physicians, we believe, are in the habit of taking their annual vacations during the summer or early autumn. Some take both a spring and autumn vacation and a few take none. These latter usually regret it sooner or later when their own health breaks down and they find that their patients can get along perfectly well without them for a brief period. It is surprising that more physicians do not take advantage of the medical meetings which occur every spring, to combine a pleasant week's trip with a profitable course of instruction. At the recent meeting of the American Congress of Physicians and Surgeons in Washington, but a small portion of Rhode Island physicians was present, although any physician in good standing and interested in the work of the special societies was perfectly welcome to attend. A meeting of the New England Section of the

American College of Surgeons was held in Portland a few weeks ago, but the attendance from Rhode Island was painfully small. Another spring meeting which should attract the profession at large is the American Medical Association in St. Louis and yet very few members attended, largely because of the distance. We Easterners are not good travelers, a fact which has been many times commented upon by the residents of the West. The physician would be greatly refreshed by a trip at this time of the year, and if his journey included a few days at one of these medical meetings, his patients would benefit from the inspiration of such a happy combination of travel and post-graduate study.

CASE REPORT

TWO SEVERE CASES OF PERNICIOUS ANEMIA TREATED BY TRANSFUSIONS.

HENRY MCCUSKER, M.D.

By permission of Dr. C. S. Westcott, I am presenting tonight two cases of pernicious anemia which were on the first medical service at the Rhode Island Hospital recently. Both cases were treated by a series of transfusions and their progress is interesting.

The first case is that of E. G., a young woman of 30, single, and white. Admitted Feb. 12, 1922, complaining of general weakness.

Her past history is negative for disease except that she had measles when a child. She came to this country from Ireland 9½ months ago in excellent health. About two months ago she had attacks of vomiting every few days before and after meals but especially before breakfast. Her vomitus was white, sour and with no particles of food or blood showing. She also complained of night sweats and slight palpitation. Her skin became very pallid. Appetite fair. No anaesthesias or paraesthesias.

Physical examination showed a young woman whose skin was of pale yellowish tint and who was apparently in much weakened condition. There was evidence of considerable loss of weight.

Head: Examination showed no gross abnormalities. Pupils equal, regular and react to light and accommodation. Ophthalmological examination showed both nerve heads pale and outlines not sharply defined, also several small recent hemorrhages. Mouth negative. Tongue somewhat swollen and reddened—not painful. Chest: Examination was negative. No rales and no signs of consolidation. Heart sounds rapid and not forcible. No murmurs made out. Blood pressure 110/55.

Abdomen: Soft. Liver edge felt just below the costal border. Spleen not enlarged. Extremities: Show moderate degree of emaciation. No disturbance in reflexes and no abnormal reflexes. No areas of anaesthesia made out on rough testing. On admission the temperature was 101°. Pulse 100. Examination of stools showed no occult blood and no eggs. The blood picture on admission was as follows: R. B. C. 800,000. W. B. C. 2,200. Hgb. 30%. Smear showed marked anisocytosis, poikilocytosis, slight polychromatophilia, a rare megaloblast and normoblast; Polys 66%, Small lymphocytes 27%, Large lymphocytes 4%, Eosinophiles 3%.

The patient's blood was typed and found to be type II, while two of her sisters also showed type II, and a third sister type IV. All had negative Wassermanns. On the third day after admission the first transfusion was done on this patient and 400 c. c. citrated blood injected with no ill aftereffects. On the next day, however, the patient began to cough, felt feverish, and then went through a fairly definite attack of broncho-pneumonia with temperature at times of 104° and pulse around 130 and 140. The R. B. C. was now 968,000 and Hgb. 30%. It was not until 18 days after the initial transfusion that the patient's condition warranted the second. Four hundred c. c. citrated blood was then given and the patient suffered no reaction. The R. C. went up to 1,296,000 with Hgb. remaining at 30%. After twelve days, the third transfusion was done and again 400 c. c. citrated blood given without a transfusion reaction. The R. B. C. in a few days was 1,656,000 and Hgb. 40%.

The patient's general condition showed marked improvement with steady gain in strength, general tone, color and appetite. Patient was now allowed out in the sun parlor in a wheel chair.

The fourth transfusion followed in 13 days and again 400 c. c. of citrated blood from a sister donor was given to the patient, who complained only of tenderness at site of the needle puncture.

The fifth and final transfusion was performed after 13 days and 350 c. c. citrated blood was given to the patient with no after effects.

Before discharge from the hospital on April 18, 1922, the R. B. C. was 1,496,000, a slight decrease over previous count. The Hgb. was 60%. There was no marked achromia, a very slight anisocytosis and poikilocytosis. No nucleated reds and a slight increase in eosinophiles.

CONCLUSION: This case shows a tremendous improvement in general condition and blood picture of a patient in a declining stage of pernicious anemia. It will be noted that this patient had an infection, to wit, a broncho-pneumonia, in her pernicious anemia course. I understand that an infectious disease in a patient with pernicious anemia is a rare condition.

The second case is that of C. H. M., 32 years of age, male, single, white, admitted on Jan. 25, 1922, with a diagnosis of pernicious anemia. On admission the patient was in a desperate physical condition.

Past History: He had ordinary children's diseases. Patient was one of 18 children, five of whom are living (besides the patient). Causes of death are not known but all died in infancy. In 1918, a local M.D. told him that he had pleurisy. He was drafted and served about a year in the American forces. Was discharged physically sound with a gain of weight of about 20 pounds.

Present Illness: Began six months ago when he consulted a doctor for fatigue and weakness and dyspnoea on exertion. After four weeks of treatment he felt as well as ever. At the same time he also took five bottles of a well-advertised patent medicine and felt so much better that he agreed to allow the use of his name as an advertisement for the medicine. About four months ago, his friends noticed that his skin was becoming yellow, but he noticed nothing unusual except that he was becoming more easily fatigued and dyspnoeic. One month ago he consulted another doctor, complaining of increasing weakness, extreme fatigue, dyspnoea on exertion and paraesthesias of extremities. These symptoms continued and he was sent to the hospital for further treatment.

Physical Examination: On admission he showed loss of about 16 pounds in a year. Skin was of lemon color. Head: Following abnormalities noted: There were many recent hemorrhages, and pigment changes resulting from old hemorrhages in each retina. Tonsils were buried. Throat granular. Mouth and tongue were not sore. No definite pathology of neck.

Chest: Well developed and expansion good. No evidence of pulmonary disease. Heart: Apex in 4th space to left of sternum in nipple line. Sounds regular and of good quality. Slight soft systolic murmur, heard over entire precordium, more marked over pulmonic area. Pulmonic second greater than Aortic second. Blood pressure 105/45.

Abdomen: Liver not enlarged. Spleen edges not felt. Abdominal wall flaccid. No masses or tenderness made out. No evidences of ptosis. Extremities: Well formed. Deeped reflexes were active but not exaggerated. Abdominal reflexes present. No anaesthesias and no paralyses. No dysmetria. From time of admission until fifth day there was temperature from 100° to 102°. Pulse was about 100. In stools no blood and no eggs were found. The blood picture was as follows: R. B. C. 800,000. W. B. C. 2,800. Differential stain showed marked poikilocytosis and anisocytosis with some polychromatophilia. A few megaloblasts were seen. Hgb. 20%. Blood was type IV. Wassermann negative. On the fifth day after his admission a transfusion was advised and his condition was considered so desperate that the transfusion was done on the ward without moving the patient from his bed to the operating room. From a selected donor I withdrew 350 c. c. blood, mixed it with 35 c. c. citrate and injected it into patient. He had no bad after-effects and slept well that night. On the next day his temperature, which had been 102° several days before the transfusion, dropped to 100° and then 99° and there was a drop in pulse. R. B. C. went to 1,688,000. Hgb. 30%.

Five days later a second transfusion was done (this time 500 c. c. of citrated blood). There were no chills or other reactions. Three days afterwards the R. B. C. was 1,456,000, a slight decrease. Eight days after previous transfusion, a third was done, and 400 c. c. citrated blood given. R. B. C. two days later was 2,200,000. Hgb. 40%. The fourth transfusion followed ten days later and 500 c. c. citrated blood was given to the patient with no reaction of any sort. The next R. B. C. was 2,424,000 and Hgb. 60%. His physical improvement continued.

After eleven days the fifth transfusion of citrat-

ed blood (500 c. c.) was performed, and the R. B. C. a week after the transfusion was 3,064,000. Hgb. 70%. The sixth and last transfusion followed the fifth by 20 days. After 250 c. c. of citrated blood had been introduced the patient complained of sharp, cramp-like pain in the abdomen and the operation was stopped. The reaction was momentary, however, and the patient felt perfectly well in a few minutes. The next morning he was up and about the ward as usual. After the third transfusion his condition improved markedly—his dyspnoea decreased and his color improved. In six weeks he had six transfusions and after every transfusion his Hgb. arose and his blood picture greatly improved. After the sixth week he was able to be up and around the ward and there was no dyspnoea and no weakness. The color returned to his cheeks and hands. His blood picture on discharge (April 1, 1922) showed R. B. C. 3,660,000, Hgb. 75%. No nucleated reds, no achromia, slight polychromatophilia and marked anisocytosis and poikilocytosis. Conclusion: This case also shows the advantages of transfusion in case of pernicious anaemia of severe degree. There were no difficulties encountered in obtaining the blood or in injecting it. There were no transfusion reactions. This case also shows the advantages of the medical man doing the transfusions for he can watch his patient and do the work without causing difficulties in transferring patient from one service to another and without increasing the anxiety of the patient.

Both of these patients have been out of the hospital a very short time and no follow-up work has yet been done on them, but it is our desire to keep them under observation for a long time in order to determine the permanency of their relief.

ANNOUNCEMENT

THE JANE FRANCES BROWN BUILDING FOR PRIVATE PATIENTS—RHODE ISLAND HOSPITAL.

A separate entrance for this building is at 44 Lockwood Street.

Direct telephone service is through the Rhode Island Hospital.

BILLS—Bills are payable weekly, in advance. Patients should come prepared to make a payment sufficient to cover the expenses of the first week. Any excess payment will be refunded.

RATES—The rates for private rooms range from $7.00 to $11.00 per day, according to the size and location. Those at $7.00 per day are for patients occupying beds in two-bedded rooms. The charges include board, ordinary medicines, the divided attention of the regular nurses on duty, which is all that is required, unless the patients are very ill.

OPERATING—A charge of $15.00 is made for the use of an operating room or a delivery room, and includes dressings and ordinary drugs.

EXTRAS—A charge of $5.00 will be made for Laboratory work ordered by the physician in charge of the patient. Special charges will be made for unusual Laboratory work as per schedule of prices.

An additional charge is made for X-ray examinations or treatments (in proportion to the amount of work done), for massage, for rare and expensive drugs and for wines, mineral waters, etc.

NURSING—The regular nursing force is quite sufficient for the necessary care of a patient, unless the patient is very ill.

A charge for the exclusive services of a graduate nurse is $6.50 per day, which includes the charge, $1.50, made for the maintenance of the nurse at the Hospital.

Persons entering the Hospital as hospital cases, that is, not as the private patients of any particular member of the Staff, will be expected to pay fees for professional services in addition to the charges made by the Hospital for board and room of patients.

If the services of a specialist or consultant are needed, it is expected that such specialists and such consultants will render separate bills for their services.

VISITING HOURS—Patients may be visited daily (subject to the order of the doctor in attendance) from 9 A. M. to 9 P. M. The visiting is limited strictly to these hours, and the friends and relatives are expected to accommodate themselves, as exceptions will be made only in case the patient is critically ill.

Relatives of patients are not permitted to remain over night with patients except in cases of critical illness, when permission is granted by the Superintendent.

Relatives or friends are not permitted to occupy

a room with a patient except in the case of parent and child, when $5.00 daily will be added to the price of the room, which charge will include meals for the parent.

In the event of critical illness, rooms may be engaged by friends at the regular rates. The Hospital reserves the right to withdraw this service upon due notice if the room occupied by friends is needed for a patient.

TELEPHONES—There are telephone connections in all bed-rooms. Instruments may be installed at the patient's expense, with the permission of the attending physician or surgeon.

VALUABLES—Valuables should be deposited with the cashier, to be placed in the Hospital safe. The Hospital will not be responsible for money or valuables unless deposited in this manner.

LAUNDRY—The Hospital will not care for personal laundry.

GRATUITY—No person employed in or connected with the Hospital is permitted to receive gratuities from the patients or from friends of patients. All are requested to respect this custom, as failure to do so will render the employee liable to immediate dismissal.

OPERATIONS—Operations will not be performed on Sundays or holidays except in emergencies.

Checks should be made payable to the Jane Brown Memorial, and all business details should be arranged with the Nurse Director in charge of the Jane Frances Brown Building for Private Patients.

CRITICISMS—It is requested that any complaints, criticisms, or suggestions for improvement of service be made at the office before leaving the Hospital.

JOHN M. PETERS, M.D.,
Director.

SOCIETY MEETINGS

RHODE ISLAND MEDICAL SOCIETY.

BUSINESS TRANSACTED BY THE HOUSE OF DELEGATES.

May 19th, 1922.

The regular meting of the House of Delegates was held this day at 5:15 P. M. in the Medical Library. The reading of the minutes of the previous meeting were omitted by unanimous vote, as these had been published in the transactions of the Society in the R. I. MEDICAL JOURNAL. The meeting proceeded to the election of officers with the following results:

President—Dr. Frank E. Peckham.

First Vice-President—Dr. Arthur T. Jones.

Second Vice-President—Dr. Wm. F. Barry, Woonsocket.

Treasurer—Dr. W. A. Risk.

Acting Treasurer—Dr. J. W. Leech.

Secretary—Dr. J. W. Leech.

Committee on Arrangements—Dr. Paul Appleton, Alex. M. Burgess, Charles F. Gormley, Treasurer.

Committee on Legislation, State and National—Drs. Frank T. Fulton, Herbert E. Harris, Henry L. Johnson, President and Secretary, ex-officio.

Committee on Library—Dr. Herbert G. Partridge, John E. Donley, Roland Hammond.

Committee on Publication—Dr. Frederick N. Brown, B. H. Buxton, P. H. Manning, Wickford, President and Secretary, ex-officio.

Committee on Education, State and National—Dr. Charles O. Cooke, John G. Walsh, Lucius C. Kingman, President and Secretary, ex-officio.

Curator—Dr. Carl D. Sawyer.

Committee on Necrology—Dr. Charles L. Phillips, John F. Kenney, Milton H. Duckworth, Carolina.

Auditor for Two Years—Dr. Frank M. Adams.

The Secretary then reported the recommendations of the Council and it was voted to approve the recommendations in re: 1. Committee to purchase stereopticon. 2. Liability insurance on Medical Library Building. 3. Salary of Librarian. 4. Salary of Janitor. 5. Repairs to Medical Library Building. The Acting Treasurer presented the Treasurer's report for the fiscal year 1921-1922, which showed expenditures of $5,642.13, receipts $7,276.25, leaving on hand a balance of $1,634.12.

Treasurer's Report.

1922 Jan. 1	Chase Wiggin Fund		
	To Loan R. I. Medical Society	$6,892 21	
		$6,892 21	
1921 Jan. 1	Chase Wiggin Fund		
	By Indebtedness to R. I. Medical Soc.		$6,892 21
			$6,892 21
1922 Jan. 1	H. G. Miller Fund		
	To Loan R. I. Medical Society	$5,359 10	
	Rent H. G. Miller Room	250 00	
		$5,609 10	
1921 Jan. 1	H. G. Miller Fund		
	By Indebtedness to R. I. Medical Soc.		$5,359 10
	Interest		250 00
			$5,609 10
1922 Jan. 1	J. W. C. Ely Fund		
	1 Bond, So. California Edison Co.	$980 00	
	8 Shares Mechanics Nat. Bank Stock	480 00	
	Paid R. I. Med. Soc. (for Journals)	74 00	
		$1,534 00	
1921 Jan. 1	J. W. C. Ely Fund		
	1 Bond So. California Edison Co.		$980 00
	Interest on same		50 00
	8 Shares Mechanics Nat. Bank Stock		480 00
	Interest on same		24 00
			$1,534 00
1922 Jan. 1	Endowment Fund		
	Cash on Hand	$2,283 38	
	Liberty Bonds 3½%	350 00	
		$2,633 38	
1921 Jan. 1	Endowment Fund		
	Cash on Hand		$2,082 74
	Donations		115 19
	Liberty Bonds 3½%		350 00
	Interest		85 45
			$2,633 38
1922 Jan. 1	Printing Fund		
	To Loan R. I. Medical Society	$1,677 52	
		$1,677 52	
1921 Jan. 1	Printing Fund		
	By Indebtedness to R. I. Medical Soc.		$1,677 52
			$1,677 52
1922 Jan. 1	Sinking Fund		
	Cash on Hand	$1,597 14	
	Total Receipts	2,002 86	
		$3,600 00	
	By Cash paid for cancellation of Bonds	$3,600 00	
1921 Jan. 1	Sinking Fund		
	Cash on Hand		$1,531 52
	Received from R. I. Medical Society		1,427 67
	Received from E. M. Harris Fund		575 19
	Interest		65 62
			$3,600 00
1922 Jan. 1	E. M. Harris Fund		
	5 Liberty Bonds	$5,000 00	
	Paid R. I. Med. Soc. (for Building)	106 25	
		$5,106 25	
1921 Jan. 1	E. M. Harris Fund		
	5 Liberty Bonds		$5,000 00
	Interest on same		106 25
			$5,106 25
	Interest on Bonds	$144 00	
	Collations	579 22	
	Printing and Postage	112 51	
	Expenses of Secretary	41 50	
	Fuel	586 03	
	Electricity	53 97	
	Telephone	67 24	
	House Supplies and Expenses	120 03	
	House Repairs	153 54	
	Insurance	15 00	
	City Water	10 21	
	Safe Deposit	6 00	
	Librarian	1,258 31	
	Books	78 00	
	Journals (Ely Fund)	59 00	
	Safe	50 00	
	Janitor	396 00	
	Tablet and Picture—Dr. Hersey	83 90	
	Rhode Island Medical Journal	400 00	
	Paid Loan to Sinking Fund	1,427 67	
		$5,642 13	
	Cash on Hand to Balance	1,634 12	
		$7,276 25	
Jan. 1	Cash on Hand Jan. 1, 1921		$2,970 98
	Annual Dues		3,400 00
	Donations		793 83
	Ely Fund, Interest on Bonds		74 00
	Interest on Daily Balance		37 44
			$7,276 25

May 15, 1922. Examined and found correct.

J. F. HAWKINS
BERTRAM H. BUXTON
Auditors.

The Secretary read his annual report, as follows:

ANNUAL REPORT OF THE SECRETARY, 1921-1922.

I beg leave to submit for your consideration a brief review of the activities and condition of the Rhode Island Medical Society as provided for by the constitution and by-laws of the Society.

There have been held three quarterly meetings during the fiscal year 1921-1922, the September meeting being held at the State Hospital for the Insane, through the courtesy of the Penal and Charitable Board.

The membership roll of the Society at present comprises: 379 active members, 26 non-resident members, 9 honorary members.

The following Fellows have died—William J. Burge, May 28, 1921; Russell M. Church, December 22, 1921; Frank H. Jenckes, October 13, 1921; Edwin S. Kiley, October 13, 1921; Joseph W. Bannon, March 16, 1922.

The following Fellows were dropped from membership for non-payment of dues—Wm. G. Dwinell, G. S. Ghazarian, Jas. H. Haberlin, John D. McGuire, Joseph Myre.

The programs of meetings for this year have been of diversified interest and have shown a tendency to revert more to the utilization of the talent of the members rather than to the importation of notable essayists from without the State. Previous annual reports of the Society have referred to this subject and it is a source of gratification that the expectations that Fellows of the Society would be able and glad to present papers of interest and scientific value have been realized and the officers of the Society to whom is entrusted the task of preparing the programs are therefore encouraged to continue along the lines of this year.

There are certain advantages accruing to an organization such as this in being representative of a small community like Rhode Island and there are also some disadvantages. The most glaring disadvantage to the Society and to the medical profession of the State is the tendency to give too much consideration to membership in large districts, such as Providence, to the subordination of the smaller, more remote, but equally as important sections from which our membership is made up. Several factors have innocently but insidiously contributed thereto—such as the actual and relative greater medical population in Providence, the location of the Medical Building here, the greater hospitalization of cities as compared to country, etc. The problem which confronts the Society is how to arrange its meetings, programs, etc., so as to make the Society have a real appeal to all the physicians in the State. The hours of meeting of this Society of late have been predicated too much upon consideration of the office hours of Providence members and too little upon the duty it owes to the whole Fellowship throughout the State. That duty is explicitly stated in Article II. of the By-Laws, which reads, "The purpose of this Society shall be to federate and bring into one compact organization the medical profession of Rhode Island." The office of Secretary of this Society is kept in close communication with similar offices in our neighboring State Medical Societies and I can assure you that the comparison of our two-hour meetings with the one- and two-day meetings of sister organizations puts us to blush.

I believe that a partial solution of the difficulty is to be found in having our meetings at an hour more suitable to out-of-town members, in having programs on a variety of subjects by at least a dozen papers, and the bulk of these papers to be presented by home talent. While in this pessimistic and fault-finding state of mind, permit me to call your attention to the shrinkage in membership of this Society. Membership in the State Society comes through membership in the District Societies and unless the Secretaries of the District Societies keep this office appraised of its new members, as the By-Laws of the State Society and District Societies provide, the Secretary cannot know to whom to send invitations to join. I, therefore, appeal again this year to the District Secretaries to send this office a list of its members and to keep it up to date by notification of added members.

Owing to the prolonged illness of the janitor of this building, it has been necessary to procure the services of another and the Chairman of the Board of Trustees, after several meetings of the Board, was instructed to engage a new janitor.

Additional insurance upon this building to total $30,000 and new insurance of $10,000 upon its contents was considered to be the minimum of safety, and by order of Council, such amounts have been placed.

In the absence of the Treasurer, Dr. W. A.

Risk, for several months, that office has been temporarily filled by the Secretary. As Dr. Risk returns this month and will be ready to resume his duties as Treasurer of the Society, I cannot relinquish the duties thus imposed upon me without expressing my sincere appreciation of the faithful and consistent services of our Librarian, Miss Grace Dickerman, without whose help I could not have handled the extra work this office entailed.

It is also a privilege and pleasure to acknowledge publicly the cordial relations and helpful consideration that have been accorded me by the President, Dr. Mathews, and the Chairman of the Board of Trustees of the Library Building in the solution of the many problems that have arisen in connection with the affairs of the Society.

Reports of the Standing Committees were made by the respective Chairmen as follows: 1. Committee on Arrangements—Dr. C. A. McDonald reported that arrangements had been made for the Annual Dinner to be held at Turk's Head Club. 2. Committee on Legislature, State and National: Dr. Frank T. Fulton—There has been during the past Legislative Session no attempt to enact any bad medical legislation, and thus there has been no opposition work for the Legislative Committee of this Society. There have been a few constructive measures more or less directed in favor of public health, which were introduced into the Legislative body, some of which have become laws. None of these, however, originated in this Committee.

What would seem to be a very important step in the co-ordination of efforts towards securing good medical legislation was taken last winter, when, upon an invitation of Dr. Frederick Green of Chicago, Secretary of Public Health Council of the American Medical Association, the Legislative Committees of New York, New Jersey, Massachusetts and Rhode Island met in New York for a conference. This conference was held during the Christmas holidays. There were in all 16 men present; from New York 2, from Massachusetts 4, from New Jersey 8, and from Rhode Island 2, namely: the President of your Society and the Chairman of your Committee. The session lasted practically the entire day, and there was very free, frank discussion. The plan which Dr. Green had to propose was that the various States should keep in more or less touch with each other and should attempt, as far as practicable and desirable, to enact the same general type of Legislative measures, at the same time recognizing that the local conditions would have to be met. It is the purpose, we understand, to have some such conference as this at least once a year.

The New York Legislative Committee is probably the most active of any of the States. Their work is very well organized, and is being made better each year. This year they sent out each week a bulletin to each County Society, stating what measures had been introduced into the Legislature, stating whether they were good and deserved support, or were bad and deserved active opposition, and each week stating the progress of each measure, whether it was in the hands of a committee and what committee, whether likely to be acted upon or not, and asking the members of the Society to use their influence with the representatives from their districts; also at times giving the names of the committee in order that they might be approached individually by their home constituents.

As result of this meeting and of the clearer understanding of the New York Committee's plan, your own Committee has asked each of the County Societies of this State to appoint a Legislative Committee in order that the Chairman of each Committee of the various County Societies may meet with your Committee whenever desirable or practicable, so that the County Societies can keep in close touch with the State Legislative Committee, and can use their influence for or against any legislation proposed. Your Committee believes that with such an organization there will be very much greater chance of bringing about good and preventing bad legislation. Such activity as is carried on by the New York State Legislative Committee involves considerable expense. They provide for this in their budget. We hope that before the Legislature again convenes that we may have an organization which may work out some such plan.

3. Committee on Library—Dr. Herbert G. Partridge: The Library has received from June 1, 1921, to May 17, 1922, 331 bound volumes, 197 reprints, 237 pamphlets. Seventeen Fellows have made gifts to the Library, and contributions have been received from many and varied sources.

There are now on the shelves and table in the

reading room, 103 journals. Of these, the Library subscribes for 33; 56 are received through exchange, and 14 are gifts. It is probable that the number of exchanges will be somewhat increased during the coming year, as certain journals which were discontinued, or at least ceased exchanging during the period of the war, will resume their former custom.

The use of the Library, both by Fellows and by the public, is constantly increasing, and it is becoming more and more what it properly should be, a clearing house for matters medical in the State. Many physicians, both Fellows and those not Fellows, come to the Library for reading or research. Others apply to the Librarian for help in finding references and other matters, so that the Library is a real help to many of the profession.

The public, comprising those in many different walks of life, apply to the Library for information on special subjects, and for more general assistance. Questions regarding physicians in other places, hospitals elsewhere, names and dates of meetings of various societies, are asked and answered by the Librarian. It seems certain that this increase in the usefulness of the Library will continue in the years to come.

Certain needs of the Library should be mentioned. Many new books are asked for which we are unable to buy because of our restricted funds, and yet it is very difficult to decide what shall be purchased in order to benefit the greatest number. Shall we endeavor to make the Library a fairly complete working Library, or shall we buy only the books which may be called reference books? By following either course, we shall displease some, and please others, but it would seem that we should look ahead and consider carefully just what books are likely to be of most lasting value.

There has been a little binding of periodicals done during the year. We have many bound sets, some of them very valuable, and it would seem that we ought to keep at least some of these up to date.

4. Committee on Publication—Dr. Frederick N. Brown:

With the publication of every periodical there must always be something yet to be desired; and this is true of the RHODE ISLAND MEDICAL JOURNAL. In the general harmony there have been a few jarring notes.

Reports of literary offerings of our District Societies, near and remote, have lacked something of the promptness and completeness that is to be desired. A report of transactions two months old is not altogether of interest; a correction of this delinquency and of this void would be appreciated.

Certain essential responsibilities connected with the publication of this JOURNAL have been accepted by a group of men and recognized by some of these as an obligation and the appreciated assistance rendered the editorial department is hereby gratefully acknowledged—many pleasant moments have been spent by the editor in contemplation of the cheerful willingness of these contributors. It is a pleasure to report that owing to the efficiency of our business and advertising management, the RHODE ISLAND MEDICAL JOURNAL has passed into a more prosperous era than has been enjoyed by it in recent years and beyond doubt the donation to the Society will exceed by at least 50% that of last year. Upon the whole, the past year has been one of some satisfaction to the Publication Committee and, it is hoped, to the Society.

5. Committee of Education, State and National—Dr. Charles O. Cooke: As Chairman of the Committee on Education, State and National, I report that the Committee has definite plans for next year and the Committee hopes to be continued.

6. Committee on Necrology—Dr. Wm. P. Buffum, Jr.: The following members have died: Dr. Joseph W. Bannon, born August 3, 1889; died March 16, 1922; member of R. I. Society November 1, 1920. Dr. William J. Burge, born April 12, 1831; died May 28th, 1921. Dr. Russell H. Church, born July 2, 1876; died December 22, 1921; member, 1912. Dr. Frank H. Jenckes, born January 26, 1860; died March 13, 1922. Dr. Edward S. Kiley, born September 10, 1869; died October 13, 1921; member, 1908.

Dr. A. T. Jones, Chairman of Board of Trustees of the Medical Library Building, presented the following report: A meeting of the Trustees was held February 6, 1922. It was voted to purchase a supply of coal for the ensuing year, which was attended to, getting a price of fifty cents (50c) per ton less than market price. It was also voted by the House of Delegates to increase the insurance on the building and furnishings

from ten thousand dollars ($10,000) to thirty thousand dollars ($30,000); also to place liability insurance to the amount of ten thousand dollars ($10,000).

These matters have been attended to and we are now sufficiently covered.

Another meeting was held April 6, 1922. Present—Drs. Leech, Mathews, Partridge, R. M. Smith, A. T. Jones.

The subject of janitor for building was discussed (on account of the injury to Mr. Waldron and his prolonged sickness, with the probability of several months more invalidism and also the probability that he would not be able to perform the several duties of janitor when he did get up and about once more). It was deemed wise to procure the services of another janitor. Mr. and Mrs. Waldron received five weeks' notice. The position of janitor was filled May 10. We have a similar arrangement to the previous one: that is, a man and his wife occupying the apartments, the man to give all of his time to the work about the building. It is necessary to pay a small amount more than the previous janitor was getting and by vote of the Trustees the wages of the present man are forty dollars ($40) per month.

The rug in the Horace G. Miller room has been cleaned and some necessary repairs made upon it. The ceiling in the assembly room has been repaired in two places, so that it is a little less unsightly. Some small repairs have been attended to, such as fixing the coal bins, attending to window cords and weights, which were absolutely necessary.

There has been very little laid out on the building since it was opened and there are many things in the way of painting and repairs that would seem necessary.

The Chairman recommends that some of this work would be attended to as soon as the finances of the Society will permit. I have one quotation for the painting of the Lecture Hall which I will turn over to the next Chairman.

Under the head of new business, the Secretary read a communication from the Secretary of the Woonsocket District Medical Society under date of April 28, 1922, extending an invitation to this Society to hold its September meeting in Woonsocket as the guests of that Society. It was unanimously voted to accept the invitation, with sincere thanks for the courtesy extended.

Dr. Buffum presented at the request of the Providence Medical Association a letter from the advertising manager of the American Medical Association as follows:

"Your members have perhaps experienced difficulty with traffic rules regulating the parking and running of automobiles.

"Several of the medical societies in the larger cities have overcome this evil by using the A. M. A. physicians' automobile emblem. For example, the Academy of Medicine, Buffalo, N. Y., succeeded in having the police officially recognize the physicians' auto emblem; it gives the right of way over all ordinary traffic; and exempts the physician's car from parking restrictions. Elsewhere the emblem has been adopted as the official insignia for members of the medical pro-societies and in Columbus, Ohio, a plan has just been inaugurated for awarding the emblem specially imprinted with the name 'Columbus' for regular attendance at medical meetings.

"Possibly this subject could be discussed at the next meeting of your Society and arrangements made with the city authorities for a special ruling. As the sale and use of the emblem is strictly limited to licensed medical practitioners, the police authorities should welcome the chance to give it official recognition.

"The standard emblem can be furnished immediately from available stocks and on a quantity order, the price to your Society would be $1.20 each, prepaid. If you can place an order for a minimum of 100, we can, with no extra charge, furnish a special emblem imprinted in blue enameled letters with the name 'Providence' across the lower third of the rim.

"The enclosed colored blotter illustrates the standard emblem. We shall be glad to send a sample emblem to display at your next meeting if you so request. Please write to us for any further information that you may need.

"Very truly yours

"WILL C. BRAUN,

"Advertising Manager."

No action had been taken by the Providence Medical Association except to refer the matter to this Society. Dr. Mowry moved for indefinite postponement of the matter, seconded by Dr. Leech. Motion lost. Dr. Brown moved that a committee be appointed to confer with the city authorities to determine what action the city would

take in regard to the question of giving traffic preference to the automobiles of physicians bearing an insignia approved by the American Medical Association. Seconded by Dr. Partridge. Motion prevailed. The President then appointed as this Committee, Drs. F. N. Brown, H. G. Partridge, W. P. Buffum, Jr. It was moved that the Committee on Legislation, State and National, be requested to investigate and report upon what action has been taken by authorized State officers to check the illegal practice of chiropractors in this State and to report at the next meeting of the House of Delegates. It was so voted.

A communication from Dr. Halsey DeWolf offering on behalf of the Rhode Island Medical Hospital Nurses serving overseas during the World War, a memorial tablet to Dr. Wm. H. Buffum, one of their members, who died while on duty, was read by the Secretary. It was voted to accept the tablet with appreciation and to provide a suitable site for its erection in the Medical Library Building. Adjourned.

J. W. LEECH, *Secretary.*

COUNCIL.

May 19, 1922.

The regular meeting of the Council was held May 19th, 1922, at the Medical Library at 4:30 P. M., Dr. George S. Mathews presiding.

The annual report of the Treasurer was presented by the Acting Treasurer and it was voted that the report, having been duly audited, be received and placed on file.

After discussion of the need of a new stereopticon for the use of the Society, it was moved by Dr. Swarts, and seconded, that a committee be appointed to pass upon the lantern to be secured, with authority to purchase same, suitable for the Society's needs and that the President be the chairman of said committee. It was so voted.

Dr. A. T. Jones, as Chairman of the Board of Trustees of the Medical Library Building, reported that liability insurance had been placed upon the building and it was voted to sanction this expense.

It was voted to recommend to the House of Delegates to make the salary of the Librarian $27.00 per week.

Dr. Jones reported that it had become necessary to hire a new janitor for the building at $40.00 per month. It was voted to recommend that the House of Delegates sanction the foregoing.

It was voted that the Council recommend to the House of Delegates granting authority to the Board of Trustees of the Medical Library Building to make repairs and of approval of necessary expenditures therefor. Adjourned.

J. W. LEECH, *Secretary.*

HOSPITALS

PROVIDENCE CITY HOSPITAL

NEWS ITEMS

Beginning in July, the Hospital will be supplied with four internes. Each interne will serve six months and two new ones will go on duty every three months. The services are divided into four parts and change every six weeks. The experience offered will not be confined to house cases but will include clinics in venereal diseases, pediatrics and tuberculosis in the Out-Patient Department.

Dr. Bruce H. Davison finishes a six months service July 1st and goes directly to the Boston Floating Hospital.

Dr. W. Clem Cheney and Wilfred W. Barber, M.D., also finish on July 1st. They are trained in pediatrics, but their future plans are not definitely formed.

On July 1st the following men begin internship; N. A. Funderbuck, M.D., Royal C. Hudson, M.D., Frank Garside, M.D., John Champlin, M.D.

The regular meeting of the Staff Association was held on May 17th, at which time the work of the past year in the Departments of Pediatrics and Medicine were reviewed statistically.